DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2003 — 17

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ -0-
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attached Addendum

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attached Addendum

10. SUBJECT OF AMENDMENT:
Managed Care Requirements

Hugh Webster

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Comments will be forwarded when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED: 9/26/03

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

ATTN: Kay Newman

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 29, 2003

18. DATE APPROVED:
December 2, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Hugh Webster

21. TYPED NAME:
Hugh Webster

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

Approved with the following changes to items 8 and 9 (authorized by State):

ADD: Attachment 4.18-A, page 3; Attachment 4.18-C, page 3; Attachment 4.18-A, page 1a; Attachment 4.18-C, page 1a

Instructions on Back

Florida State Plan Amendment 2003-17 Managed Care Requirements
Addendum to CMS form 179

Box 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 4.13, pages 45a and 45b
Attachment 2.2-A, page 10a
Section 3.1(a), page 22
Section 4.29, page 77
Section 4.18, pages 54 and 55
Section 4.14, pages 46 and 50a
Section 4.30(b), page 78a
Section 4.10, page 41
Attachment 2.2-A, page 10
Section 1.4, page 9
Section 4.23, page 71
Section 4.30, page 2
Section 2.1, page 11
List of Attachments

Box 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Section 4.13, pages 45a and 45b
Attachment 2.2-A, page 10a
Section 3.1(a), page22
Section 4.29, page 77
Section 4.18, pages 54 and 55
Section 4.14, pages 46 and 50a
Section 4.30(b), page 78a
Section 4.10, page 41
Attachment 2.2-A, page 10
Section 1.4, page 9
Section 4.23, page 71
Section 2.1, page 11
Attachment 2.1-A
List of Attachments

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Florida

Citation			
1902 (a)(58)			
1902(w)	4.13	(e)	For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

State: Florida

Agency*	Citation(s)	Groups Covered

1932(a)(4) of Act — B. Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

_X_ Disenrollment rights are restricted for a period of _12_ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

___ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an

MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

_X_ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Florida

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

There is a copayment charge to recipients 21 years of age and older who are not pregnant, in institutions, nursing homes, ICF/DDs, or receiving hospice care or family planning services. Providers are prohibited from denying services to recipients who are unable to pay their copayment. Basis for determination was the maximum allowable charges in 42 CFR 447.54 (a)(3) and 447.55(b).

Effective July 1, 1993, a $2.00 copayment applied to the following services:
Physician Services: New or established patient office/outpatient services, office/outpatient consultations, and general ophthalmological services.

Optometric Services: New or established patient office/outpatient services, and office/outpatient consultations.

Oral Surgeons: New or established patient office/outpatient services, and office/outpatient consultations.

Effective July 1, 1995, a copayment applies to the following services:
Inpatient Hospital: $3.00 copay per admission.

Outpatient Hospital: $3.00 copay per visit.

Rural Health Clinic: $3.00 copay per day per provider per recipient.

Federally Qualified Health Center: $3.00 copay per day per provider per recipient.

Osteopath, Physician, Physician Assistant, Nurse Practitioner, Podiatrist, or Optometrist: $2.00 copay per day per provider per recipient.

Home Health Agency: $2.00 copay per day per provider per recipient.

Community Mental Health: $2.00 copay per day per provider per recipient.

Independent Laboratory: $1.00 copay per day per provider per recipient.

Portable X-Ray Company: $1.00 copay per day per provider per recipient.

Chiropractic Services: $1.00 copay per day per provider per recipient.

Transportation: $1.00 copay per trip.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Due to the nature of the services subject to coinsurance, enforcement of the cost sharing exclusions is accomplished by simple MMIS edits flagging recipients who are:

1. Under 21 years of age,
2. Institutionalized,
3. Pregnant,
4. Receiving family planning drugs/supplies,
5. Receiving trial prescriptions of anti-arthritis drugs or anti-hyperlipidemics when required.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Florida

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

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5. Receiving trial prescriptions of anti-arthritis drugs or anti-hyperlipidemics when required.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below:

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State: Florida

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /X/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), ~~and~~ 1925(b)(4), and 1932 of the Act

(a)(10) Comparability of Services

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/X/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits annual encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

New: HCFA-PM-99-3
JUNE 1999

State: Florida

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Florida

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.